MAXIMUS Federal Services

Case Number:	CM14-0001894		
Date Assigned:	02/07/2014	Date of Injury:	07/10/2001
Decision Date:	06/16/2014	UR Denial Date:	12/14/2013
Priority:	Standard	Application Received:	01/07/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Neurosurgery, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 56 year old female who sustained an injury on 07/10/01 while performing repetitive activities. The patient has been followed for a diagnosis of complex regional pain syndrome. It is noted the patient has had prior surgical procedures for the right shoulder. As of 10/30/13, the patient was seen for continuing chronic pain in the right shoulder that was aggravated by any activity. This was exacerbated by any working activities. Physical examination demonstrated loss of range of motion in the right shoulder. There was allodynia present in the right anterior and posterior upper extremity. There was limited range of motion in the right shoulder with associated edema. Medications at this visit included Mexiltine, Lidoderm patches, and Gabapentin. The patient was utilizing a back and body BUOY system with stabilizers. There were recommendations for physical therapy at this evaluation. The BUOY system was recommended in order to reduce the amount of pressure being placed on the low back which would overall allow a reduction in allodynia symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

BODY BUOY, BACK BUOY, STABILIZERS, WAIST BAND, SPACER ELEMENT, AND SPACULAR ADDUCTION PADS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation ODG Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

Decision rationale: The patient has ongoing allodynia secondary to the development of right frozen shoulder that was partially improved with manipulation under anesthesia procedures. The patient was also diagnosed with thoracic outlet syndrome. The clinical notes documented that the body BUOY system was recommended to hopefully reduce the amount of pain secondary to pressure while sitting. The use of low back supports similar to the body and back BUOY system has limited evidence within the clinical literature in its ability to treat or prevent chronic low back pain. The clinical literature has not shown that stabilizer systems similar to the body and back BUOY system result in any long term functional improvement as compared to an exercise program or other physical therapy. Therefore, the request is not medically necessary and appropriate.

GABAPENTIN: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIEPILEPTICS Page(s): 16-22.

Decision rationale: In regards to the use of Gabapentin, the patient does present with continuing neuropathic symptoms in the right upper extremity with associated allodynia. Gabapentin is a recommended 1st line medication in the treatment of neuropathic pain. Given the objective findings noted in the clinical record regarding ongoing and persistent allodynia and neuropathic pain, the request ismedically necessary.

LIDODERM PATCHES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM Page(s): 56.

Decision rationale: The patient does present with neuropathic symptoms in the right upper extremity with associated allodynia. The MTUS Chronic Pain Guidelines do indicate that Lidoderm patches can be considered as an option in the treatment of neuropathic pain when there has been clear failure of other 1st line medications to address neuropathic pain such as anticonvulsants or antidepressants. As the patient is currently utilizing Gabapentin with reported functional benefits, the use of Lidoderm patches is not currently indicated. The request is notmedically necessary and appropriate.

MEXILTINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation HTTP://WWW.NCBI.NLM.NIH.GOV/PUBMED/11009230

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: MEXILTINE. (2013). IN PHYSICIANS' DESK REFERENCE 67TH ED.

Decision rationale: In regards to the use of Mexiltine, there are no indications for this medication in the treatment of neuropathic pain. Mexiltine is indicated in the treatment of ventricular arrhythmia such as ventricular tachycardia. There are no other indications for this medication that would support its use in this case. Therefore, this medication is not medically necessary and appropriate.